

Patient Perspectives on Technology-Based Approaches to Social Needs Screening

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Social determinants are increasingly being recognized as upstream drivers of health.¹ Given the broader awareness of this impact and the adoption of alternative payment models that incentivize addressing social needs,^{2,3} expectations are growing that health systems will screen for patients' social needs. Several studies have examined clinician attitudes toward social needs screening, finding that clinicians largely endorse the need for screening despite structural limitations to addressing identified needs^{4,5} and limited clinician comfort in inquiring about or referring for social needs.⁶ To date, however, there is inadequate evidence on how patients prefer to be engaged around social needs; prior literature in this space has largely focused on which needs patients identify and whether they desire assistance,⁷ as well as whether patients believe social needs are related to their health or approve of being screened.^{8,9} Additionally, no studies have examined patient perspectives on modalities through which health systems screen for social needs (eg, telephone, paper, portals, tablets). The aim of this study was to understand patient perspectives on completing social needs screening through various modalities.

METHODS

We interviewed patients from 3 urban internal medicine practices at Penn Medicine, a large academic health system in Philadelphia, from November 4, 2021, to April 14, 2022. The study was exempted from full review by the University of Pennsylvania institutional review board.

Penn Medicine's standardized social needs survey uses validated items¹⁰ ([eAppendix](#) [available at [ajmc.com](#)]) to screen patients about exercise, stress, finances, education, food insecurity, transportation, alcohol, and housing. Patients are eligible for the survey if they have not completed it in the past year and are scheduled for a nonacute primary care visit. If patients have an active portal account, they receive the survey via portal 3 days before these visits. In 2022, tablets were introduced in the waiting room at 1 of the practices for patients to complete the survey if they had not already done so via portal, regardless of their portal activation status.

ABSTRACT

OBJECTIVES: Social determinants have an outsized impact on health outcomes. Given the increasing awareness of this impact and the adoption of alternative payment models that incentivize addressing social needs, expectations are growing that health systems will appropriately screen for patients' social needs. However, there is limited evidence on how patients would like their health systems to engage with them around these needs. Our objective was to understand patient perspectives on completing social needs screening through technology-based modalities.

STUDY DESIGN: We performed a qualitative study with semistructured patient interviews from November 2021 to April 2022.

METHODS: Patients were eligible for our health system's standardized social needs screening survey if they had not completed it in the past year and were scheduled for a nonacute primary care visit. Patients were selected for interview if they completed the survey via portal or tablet or if they were eligible for but did not complete the survey. Interviews were analyzed using an integrated approach. Domains, subdomains, and themes were identified.

RESULTS: We completed interviews with 54 participants. Participants were broadly accepting of screening, and most were comfortable with portal or tablet-based screening. They were motivated to complete the screening and recognized the connection between social needs and health. Having a trusting relationship with their clinician and feeling that their information was private were noted by patients as important factors for process endorsement.

CONCLUSIONS: This qualitative study provides insight into patient-centered approaches for identifying patients' social needs.

Am J Manag Care. 2023;29(1):e18-e23. doi:10.37765/ajmc.2023.89309

Sample and Outreach

Patients were interviewed if they completed the survey via portal or tablet or if they were eligible for but did not complete the survey. Stratified sampling was used to ensure that the perspectives of patients from each subgroup were adequately represented. Equal numbers of patients among subgroups were targeted for interviews until thematic saturation was observed.

Interview guides were developed based on a review of relevant literature and study team expertise in primary care health services research and qualitative methods. Guides were piloted and adjusted based on interview feedback. Semistructured interviews explored patient perspectives in the domains of motivation for screening and components of the screening process, including modalities used, timing, and interprofessional involvement. Interviews were conducted over the phone and recorded by 2 study team members (A.J.H. and K.H.); each lasted an average of 11 minutes (range, 5-34 minutes). Eligible patients were contacted in the month following their visit to assess interest in being interviewed, with compensation of \$20 for their time. Verbal informed consent was obtained before all interviews.

Data Collection and Analysis

Interview data were coded utilizing an integrated approach.¹¹ First, a priori codes for themes within the domains identified in the development of our interview guide were assessed; then, a memoing process identified themes emerging from the data that were not accounted for in the a priori coding schema. Early interviews were coded by the full study team to develop the coding schema. Debriefing meetings and memos were intended to identify potential impacts related to reflexivity.¹² Interview data were coded by 2 study team members (A.J.H. and K.H.) until thematic saturation, with approximately 20% of the data double-coded to assess consistency and coding definition consensus.

RESULTS

Interviews were completed with 20 patients who completed the survey via portal (portal responders), 14 patients who completed the survey via tablet (tablet responders), and 20 patients who did not complete the survey (nonresponders) (Table 1). Participant demographics were reflective of those of our overall patient population.

Domains reviewed included motivation for and process components of survey completion (Table 2). The themes identified within these domains are summarized below.

Motivation for Survey Completion

Most participants were accepting of being screened for social needs and felt it was appropriate for their practice to do so.

TAKEAWAY POINTS

Interviews with patients provided critical insights into patient-centered approaches through which health systems could identify social needs.

- ▶ Patients were broadly accepting of screening, and most were comfortable with portal or tablet-based screening.
- ▶ Patients were motivated to complete the screening and recognized the connection between social needs and health.
- ▶ Having a trusting relationship with their clinician and feeling that their information was private were noted by patients as important factors for process endorsement.
- ▶ Based on these findings, we provide suggestions for health systems looking to implement patient-centered social needs screening as this practice becomes more widespread.

TABLE 1. Characteristics of Patient Interview Participants (N = 54)

| Characteristic | Participants, n (%) |
|-------------------------------|---------------------|
| Gender | |
| Female | 37 (69%) |
| Age in years | |
| 20-29 | 4 (7%) |
| 30-39 | 6 (11%) |
| 40-49 | 9 (17%) |
| 50-59 | 12 (22%) |
| 60-69 | 15 (28%) |
| 70-79 | 8 (15%) |
| Race | |
| Black | 41 (76%) |
| White | 10 (19%) |
| Asian | 2 (4%) |
| Other | 1 (2%) |
| Ethnicity | |
| Hispanic/Latino | 2 (4%) |
| Payer | |
| Commercial | 22 (41%) |
| Medicaid | 15 (28%) |
| Medicare | 16 (30%) |
| Uninsured | 1 (2%) |
| Modality of survey completion | |
| Patient portal | 20 (37%) |
| Tablet | 14 (26%) |
| Did not answer survey | 20 (37%) |
| Portal account status | |
| Active | 44 (81%) |
| Reported social needs | |
| Financial strain | 16 (30%) |
| Food insecurity | 15 (28%) |
| Transportation barriers | 11 (20%) |

TABLE 2. Domains, Subdomains, and Themes From Qualitative Analysis

| Domains | Subdomains | Themes |
|------------|---------------|--|
| Motivation | | Social needs screening has the potential to open dialogue and catalyze more holistic care. |
| | | Some patients experience shame and fear around the sensitivity of social needs. |
| Process | Modality | Patients value convenience, ease, and efficiency when being screened for social needs. |
| | | Patients desire human connection when being screened for social needs. |
| | Interpersonal | Patients have concerns around data confidentiality when sharing social needs with their health system. |
| | | A patient’s relationship with their clinician influences their comfort with sharing social needs with their health system. |
| | Timing | Power dynamics are a barrier to patients feeling comfortable sharing their social needs. |
| | | Patients perceive barriers to completing social needs screening in the waiting room setting. |
| | | Patients prefer to preserve visit efficiency and time with clinicians over completing social needs screening. |

Social needs screening has the potential to open dialogue and catalyze more holistic care. Many participants reported that the survey gave them space to discuss issues they otherwise would not have expressed: “I often look at the doctor’s office as somewhat of a therapy. When you ask those kinds of questions...it gets a person to feel their doctor is concerned. And you’re in a private setting to talk about something that’s going on at home that you’re too afraid to talk about with anyone else.” (portal responder)

Further, several participants felt that completing the survey could help their clinician see things the participant couldn’t see themselves, describing conversations stemming from the screening process as “magnifying” their issues to make them more visible: “Most people, if they have problems with booze or drugs, tend to want to keep that to themselves. I can answer that because I’m one of those people that had one of those issues. I lied to my doctors when I was younger so [they] would give me more drugs. Sometimes it’s the catalyst that makes people start to think about their problems... That moment you do say something, where you’re honest, is when they can help you.” (tablet responder)

Participants felt that social needs were related to health, with many endorsing direct linkages through stress, diet, and exercise. In turn, many participants felt that the screening gave their clinicians a more complete picture of their health, which would allow them to provide more holistic care.

Some patients experience shame and fear around the sensitivity of social needs. Although most participants felt open to answering the survey, a subset expressed reservations given topic sensitivity: “Food scarcity sounds like a topic that would concern me because it would be hard to admit or you feel like you are letting your family down, so that would seem the most sensitive.” (tablet responder)

Barriers stemming from this sensitivity included fear, pride, and the feeling that these questions invaded patient privacy: “As a younger man, I didn’t like asking for help...I just wanted in and out and I didn’t want to be bothered....I’m a little older now, and a little smarter too. Now, when somebody offers help, I learned to accept it. Pride and fear were holding me back before.” (tablet responder)

Additionally, several participants felt topic sensitivity combined with a perceived lack of transparency around why they were answering the survey generated hesitancy about completing it, with one nonresponder perceiving that the survey was “market research.” Participants therefore felt it was important for the survey to be prefaced with its purpose: “Maybe you would want to list the purpose [of the survey] so it feels like it’s to help you. Would help a person know why they are answering these questions.” (tablet responder)

Finally, many participants noted that survey modality could influence the risk of disclosures being limited by shame, most commonly endorsing that they would feel more comfortable providing honest answers on asynchronous surveys rather than face to face: “Some people will tell the truth if they’re not in front of somebody. This is where a form may be better.” (portal responder)

Modality of Survey Completion

Participants preferred the use of tablets, paper, and face-to-face screening for social needs, with some endorsement of portal-based screening and sporadic endorsement of other modalities (eg, call, text, email).

Patients value convenience, ease, and efficiency when being screened for social needs. More than any other factors, participants highlighted the convenience, ease, and efficiency of a modality as drivers of their preferences. However, there was variation around which modality was deemed the most convenient, easy, or efficient. Several participants emphasized the convenience of the portal, given their reliance on it for managing other health-related needs: “I loved that they have it all in [the portal], it was easy to follow. I just love having the access to log onto my account and look up different things or take surveys or request blood tests or whatever kind of test that I need.” (portal responder)

Notably, the most commonly cited reasons for not completing the survey among nonresponders were lack of time to complete it before their visit and not seeing the survey among all the other previsit information they received. Some participants noted that distractions competed for their attention when completing assessments via

portal, and they struggled to identify screening requests via portal, given opaque messaging and information overload: “I might’ve seen the note, but I thought it was just a visit reminder. However it was delivered to me, it wasn’t clear it was a survey....People are so bombarded with information.” (nonresponder)

Some participants highlighted preferences for tablet, paper, or face-to-face screening to allow for survey completion during visit waiting periods when patients are already “captive,” thus sparing them the inconvenience of survey completion on their own time. Phone-based assessments were challenged by participants noting a high volume of phone-based scams and limited ability to answer a call.

Several participants preferred technology-based screening over paper, finding it “easier and quicker to click an answer than write it out” and thought the practice may benefit as well: “[The tablet is] easier than paper for both patients and practices. Makes it easier to keep track and could connect to your record. Easier to read than handwriting.” (nonresponder)

Barriers to technology-based screening included challenges with technology access or comfort, difficulty reading phone-based text, and language and literacy issues. However, several participants noted that despite not being “computer people,” they were open to completing the survey using technology so long as someone assisted them: “I am familiar with [the portal] but I don’t use it....I’m probably an old-fashioned person but I know in the long run it’s necessary, so I need to do it. I just need someone to walk me through it.” (tablet responder)

Finally, several participants endorsed surprise at how easy the survey was to complete via a tablet, despite prior difficulty using technology.

Patients desire human connection when being screened for social needs. Several participants preferred face-to-face or phone-based screening because these felt more personal than electronic modalities. One participant desired face-to-face screening given their preference for eye contact, whereas others valued “talking to a person” because this would allow them to ask questions: “A phone call would give some interactivity instead of just blasting out information to people. It gives people a chance to ask questions.” (nonresponder)

Patients have concerns around data confidentiality when sharing social needs with their health system. Most participants felt comfortable sharing social needs with their practices and having anyone on their clinician’s team see this information, with many reporting the belief that anything they shared would be kept private and wouldn’t be used in any way other than to help them: “I would be fine with anyone seeing my information....It’s a team thing. I feel comfortable because of the [Health Insurance Portability and Accountability Act] laws as well, and I feel like the whole team should be aware of how to address the patient.” (portal responder)

However, there were several concerns around the confidentiality of patients’ social needs information. Some participants reported concerns that nonphysician team members, such as front desk staff,

would breach confidentiality by talking about or mocking patients about their disclosures.

Finally, one participant felt that emphasizing the survey’s confidentiality would help patients open up: “You should emphasize that it’s confidential. It wasn’t clear to me whether it was confidential or not.” (tablet responder)

Interpersonal Drivers of Survey Completion

Most participants had no clear preferences for which practice personnel should be involved in screening. For those with preferences, physicians and social workers were preferred, with some endorsement of nursing and other clinical staff.

A patient’s relationship with their clinician influences their comfort with sharing social needs with their health system. Several participants expressed that a strong relationship with their clinician was a prerequisite for comfort discussing social needs, and many attributed their comfort in answering the survey to trusting their clinician: “If I didn’t like my doctor so much, I don’t know that I’d feel as comfortable answering those questions....I especially trust my doctor, who is like the best doctor in the world, so I would trust all his staff too and think that they’re only asking those questions to help me.” (portal responder)

For other participants, their relationship with their clinician meant they would want to engage with only their clinician around social needs, not other practice staff: “Personally, I would prefer my provider because there are a lot of personal and private things I would only like to share with my provider.” (nonresponder)

However, one participant preferred discussing social needs with a nurse because they felt it may be easier to discuss potentially “shameful” topics with someone they didn’t know as well as their clinician.

Power dynamics are a barrier to patients feeling comfortable sharing their social needs. Occasionally, participants endorsed power dynamics—particularly around status, race, and gender—as an influence on their comfort level when engaging with their practice around social needs: “It can be hard to answer truthfully depending on some things....It’s hard to talk about money because you kind of always want to seem like you have it. I’m African American and my doctors are usually not the same race as me. I don’t want to come off poor to them.” (nonresponder)

For some patients, this manifested in a greater level of comfort sharing their social needs with practice staff members other than physicians: “I would like the staff who puts me in the room [to ask me about social needs], because my experience with the staff... it’s a comfortability thing. I feel like they’re on my level....A lot of doctors, they make you feel like they are above.” (nonresponder)

Timing of Survey Completion

Participants expressed a wide array of preferences around how frequently patients should be screened for social needs, with most endorsing every visit or annually, but with many preferring some cadence in between. Many noted that optimal frequency will vary by patient depending on their needs and visit frequency.

Patients perceive barriers to completing social needs screening in the waiting room setting. Although most participants responded positively to the idea of being surveyed in the waiting room before their visit, a subset reported concerns about this setting. Some felt the waiting room lacked privacy from other patients, particularly with face-to-face and paper-based screening, whereas others felt the turbulence of the waiting room would prevent them from answering the survey thoughtfully: “[My doctor’s] office is packed... Everything is so fast, you walk out of there feeling empty, like you just went through the motions.” (nonresponder)

Patients prefer to preserve visit efficiency and time with clinicians over completing social needs screening. Many participants valued visit efficiency and preservation of their time with their clinician when considering preferred timing for social needs screening. Several expressed hesitation around completing the survey before their visit out of a concern that this may delay seeing their clinician. Some participants preferred to discuss social needs with a nonclinician before or after their visit given the volume of other topics they wanted to discuss with their clinician, whereas others preferred to be screened before their visit to enable a follow-up conversation with their clinician, thus making their time together more valuable. Finally, several participants expressed a desire to avoid providing the same information multiple times, either through the check-in process or by answering the same questions from multiple personnel during their visit: “I have some pretty strong feelings on this....I answer the same set of questions to 3 different people and then I get 5 minutes with the doctor.” (tablet responder)

DISCUSSION

This study assessed patients’ experiences with and perceptions of social needs screening, identifying themes from the domains of motivation and process components. Participants provided critical insights into more patient-centered approaches through which health systems could identify social needs. Participants were broadly accepting of screening, and most were comfortable with portal or tablet-based screening. Participants were motivated to complete the screening and recognized the connection between social needs and health. Having a trusting relationship with their clinician and feeling that their information was private were noted as important factors for process endorsement.

As the practice of collecting patients’ social needs becomes more widespread, and as patients come to expect their clinicians to address social needs, we propose the following suggestions for health systems that seek to implement patient-centered social needs screening:

1. Educate clinicians and staff about the patient experience of social needs screening to promote a shared understanding of the process.
2. Develop patient-facing language for screening surveys to clarify their purpose and confidentiality.

3. Provide quiet and private disclosure environments, or privacy-enhancing survey features such as tinted screen protectors for tablets.
4. Leverage technology-based screening to maximize convenience and efficiency, while retaining alternatives such as paper-based or face-to-face screening for patients with barriers to technology use.
5. Support patient choice in survey completion, modality, and frequency.
6. Invest in high-quality interdisciplinary teams to obtain the expertise required to meaningfully address patients’ social needs while preserving the patient-clinician interface.

Limitations

Our study had several limitations. The qualitative data presented should be used for hypothesis generation and not causal inferences. Social desirability bias may have affected responses, as it was noted that social needs screening was a sensitive topic. Patients were purposively sampled based on screening response modality with attention to sampling patients who did not complete screening to support a broader range of experiences and presumed preferences. However, recruitment was limited to a single health system, limiting the generalizability of findings.

CONCLUSIONS

We found that patients have specific preferences for how they would like their practices to engage with them around social needs. Before social needs screening can be effective, more work is needed to reimagine practice workflows and payment models, invest in community-based resources, and develop accessible modes of patient engagement. ■

Acknowledgments

The authors acknowledge the contributions of Darlene Mosley, Teodoro Rios, and the Division of General Internal Medicine at Penn Medicine for their support of this work.

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Source of Funding: This work was supported by the Sam Martin Education Grant from Penn Medicine’s Division of General Internal Medicine.

Prior Presentation: Part of this work was presented at the Society of General Internal Medicine Annual Meeting on April 6, 2022.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (AJH, AUM); acquisition of data (KH); analysis and interpretation of data (AJH, KH, PFC); drafting of the manuscript (AJH); critical revision of the manuscript for important intellectual content (PFC); provision of patients or study materials (SS-M); administrative, technical, or logistic support (KH, SS-M, AUM); and supervision (PFC, SS-M, AUM).

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eAppendix. Penn Medicine's standardized social needs screening survey

We want to give you the best services and care possible to meet all of your needs. Your choice to answer or to not to answer any questions will NOT impact your ability to get care at Penn Medicine. In many cases, your answers will help us find out if there are any programs or supports that can give you added benefits and care. We cannot promise help in all areas, but will do our best to find ways we can help based on your priorities. Please let us know if you have any questions, concerns, or thoughts.

1. On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)? [0 days, 1 day, 2 days, 3 days, 4 days, 5 days, 6 days, 7 days, decline]
2. On average, how many minutes do you engage in exercise at this level? [0 minutes - - 150 or more minutes, decline]
3. Do you feel stress - tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled all the time - these days? [Not at all, Only a little, To some extent, Rather much, Very much, Decline]
4. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? [Not hard at all, Not Very Hard, Somewhat hard, Hard, Very hard, Decline]
5. What is the highest level of school you have completed or the highest degree you have received? [1st grade, 2nd grade, 3rd grade, 4th grade, 5th grade, 6th grade, 7th grade, 8th grade, 9th grade, 10th grade, 11th grade, 12th grade, GED or equivalent, Associate degree: occupational, technical, or vocational, Associate degree: academic program, Bachelor's degree (e.g., BA, AB, BS), Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA), Professional school degree (e.g., MD, DDS, DVM, JD), Doctorate, Some college, no degree, Never attended school, Decline]

6. Within the past 12 months, you worried that your food would run out before you got the money to buy more [Never true, Sometimes true, Often True, Decline]
7. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more [Never true, Sometimes true, Often True, Decline]
8. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications? [Yes, No, Decline]
9. In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living? [Yes, No, Decline]
10. How often do you have a drink containing alcohol? [Never, Monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week, Decline]
11. How many drinks containing alcohol do you have on a typical day when you are drinking? [1 or 2, 3 or 4, 5 or 6, 7 to 9, 10 or more, Decline]
12. How often do you have six or more drinks on one occasion? [Never, Less than monthly, Monthly, Weekly, Daily or almost daily, Decline]
13. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? [Yes, No, Decline]
14. In the last 12 months, how many places have you lived? [Free text entry]
15. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)? [Yes, No, Decline]
16. If you identified a need with any of the areas included in this questionnaire, would you like assistance? [Yes, No, Decline]